CENTE	RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		FOR	:D: 10/13/20 :M APPROVE
STATEMEN	T OF DEFICIENCIES			E O E I W E I OMBN	O. 0938-03
AND FLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	P COME DATE	SURVEY
		185168	B. WING _	101 OCT 22 2010	
NAME OF P	ROVIDER OR SUPPLIER				129/2010
MONRO	E licai tu and deur	LPRPI SIM A lost do n.a. do man do	7	REIT ADDRESS, CITY, STATE, ZIP CODE	
1410/41/01		ABILITATION CENTER	т т	ON PKWINGHEMORGEMENT Branch	
(X4) ID PREFOX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	Œ	PROVIDER'S DI AN OF CORDECTION	MEI
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIK
			i Aug	DEFICIENCY)	DATE
F 000	INITIAL COMMENT	'S	F 000		·
	Harris and Colorina (Color		F 000	The submission of this plan of	
	A standard kIII-			correction does not constitute an	
Ì	September 27 00 C	urvey was conducted on		admission by the provider of any fact	
	identified with the hi	2010. Deficient practice was ghest scope and severity at	<u> </u>	or conclusion set forth in the	
-	"F" level with no su	bstandard quality of care		Statement of Deficiency. This plan is	<u>.</u>
	identified.	postalidade desiry of cale		being submitted because it is	
F 281	•	VICES PROVIDED MEET	F 281	required by law.	
SS=D	PROFESSIONAL S	TANDARDS	F 201	required by law.	
				F281	
	The services provide	ed or arranged by the facility	1		
1	must meet profession	onal standards of quality.		1) Resident #2's water pitcher	
Ì		• .	:	was refilled to the proper level.	
	This DECUMENTAL	T 1 1 1	!		
	by:	T is not met as evidenced		Potatoes were removed from	
.		on, interview, and record	į	resident #2's tray and resident	
Ì	review, the facility fa	iled to follow physician's	- ;	was provided with a substitute.	
	orders for one (1) of	twenty-three (23) sampled	1	On 10/19/10 Hydration Nurse	
1	residents. Resident	#2 had physician's orders for	1	reeducated resident #2 on the	
•	food and fluid restric	tions; however, the resident		amounts of fluid she was allotted	
	was served food tha	t was on the restricted list			
	and more fluids than	the amount allotted.		throughout the day.	
	The findings include:			2) No other residents in the	
·	The findings include:	•			
l,	A review of the medi	cal record for resident #2		building are on a fluid restricted	
1	revealed the residen	t was admitted to the facility		diet. On 10/25/2010 at tray line	
	ол March 17, 2010, v	with diagnoses that included		all diet tray cards will bechecked	ĺ
, (Chronic Kidney Dise	ase, Hypertension,	-	for accuracy by the dietary	
		labetes. Further review		manager. All physician orders	
		sician's orders restricting		are being followed by the dietary	
į į	nuids for resident #2	to 1400 cubic centimeters		staff members.	
. []	(w) o nuids daily. If	n addition, resident #2 had r a Renal Consistent		Aacht inclination	
1 8	Carbohydrata Diet w	ith no tomatoes, no potatoes,		3) On 10/22/2010 Dietician	
	and no dried beans,	is no tomatoes, to poisioss,		•	
. [educated Dietary staff members	
(Observations of the	evening meal on September		on the importance of following	
:	27, 2010, at 7:15 p.m	n: EDT, revealed resident #2		the tray cards. On 11/5/2010 the	
	······································	R/SUPPLIER REPRESENTATIVE'S SIGN		TILE	1

Any deficiency statement anding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing hornes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing hornes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsotete

Event ID: TQHT11

Facility ID: 100367

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PRINTED: 10/13/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, DF CODE MONROE HEALTH AND REHABILITATION CENTER 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 281 Continued From page 1 F 281 DON will reeducate all nursing was served a meal that included sweet potatoes. and dietary staff members on the 240 cc of coffee, and 120 cc of juice. In addition, the resident's water pitcher was three-fourths full importance of following the of water and was available for the resident to facility's fluid restriction policy. Nursing staff members will be An interview with resident #2 conducted at 7:25 reeducated on the importance of p.m. on September 27, 2010, revealed the checking tray cards while serving resident was "not sure" if her/his fluids were residents' trays. limited. The resident stated, "I don't know how much I can have." 4) Dietary manager or her An interview with Certifled Nursing Assistant designee will observe tray line (CNA) #1 conducted on September 27, 2010, at weekly for four weeks and then 7:26 p.m., revealed CNA #1 had served the monthly thereafter to ensure supper tray to resident #2. CNA #1 stated he/she that tray cards are being did not look at the tray card to check for accuracy and was not aware the resident was not permitted i followed by the dietary staff to have potatoes, members. Hydration nurse will perform a QA at least weekly to An interview with CNA #2 conducted on September 27, 2010, at 7:30 p.m., revealed CNA assure that we are following fluid #2 served the resident a cup of coffee in addition restriction orders. Results will be to the juice served on the tray. CNA #2 stated, "I reviewed by the administrator knew the resident's fluids were limited, but we weekly and will be reported to don't really pay attention to it." the QA committee quarterly. An interview with Licensed Practical Nurse (LPN) #1 conducted on September 27, 2010, at 7:30 11/12/2010 p.m., revealed LPN #1 saw the coffee and juice on the tray, but assumed the resident had received the appropriate amount of fluid and did not question it. An interview with the Dietary Manager conducted on September 27, 2010, at 7:33 p.m., revealed the staff responsible for checking trays for accuracy was newly hired, and "just missed it."

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOHT11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2010 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		186168	B, WING			09/29/2010	
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIF CODE		0,20 70
MONROE HEALTH AND REHABILITATION CENTER					OB N MAGNOLIA STREET, PO BOX 36 OMPKINSVILLE, KY 42167	i7 .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH GROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 281	An interview with R	egistered Nurse (RN) #1, who	F:	281	F-318		
F 31B	was responsible for hydration, was conducted on September 28, 2010, at 8:30 a.m., and revealed the staff was aware of the resident's fluid limitations and was not supposed to fill the water pitcher up.		F.	318	1) An order for Occupations Therapy related to resident left hand was obtained on 10/4/2010. The resident is		
\$\$ = D				receiving occupational then five times per week with a r plan of care for contracture	new		
				•	preventative measures. 2) By 11/8/2010 all resident be screened by the DON or ADON to assure that any de in ROM are identified and the	clines	
	by: Based on observation review, the facility fatwenty-three (23) sa	IT is not met as evidenced on, interview, and record alled to ensure one (1) of impled residents received ont and services to prevent a			residents' plan of care is individualized for residents needs. Necessary changes be made.		
•	decrease in range of assessed to have in left hand; however,	f motion. Resident #5 was negative range of motion of the there was no evidence the ad interventions to improve or			3) On 10/20/10 the Director Nursing educated ADON on proper way of assessing resident's joint mobility and documenting results on the	the I on	
	#5 was admitted to 2000, with diagnose Syndrome, Chronic Disease, Senlie Der Thoracic Aortic Ane	ical record revealed resident the facility on February 4, es of Nonpsychotic Brain Obstructive Pulmonary nentia, Hypertension, and urysm. A review of the omprehensive assessment			Mobility Assessment. On 10/21/10 DON will educate ADON and therapy staff members on individualizing restorative interventions according to resident's limit All residents will be screene	ation.	

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Event ID: TQHT11

Facility ID: 100367

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					0: 10/13/2010
		& MEDICAID SERVICES					APPROVED 0, 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185168	B. WI	NG	1	09/	29/2010
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		23/20 10
MONRO	E HEALTH AND REHA	ABILITATION CENTER		708	6 N MAGNOLIA STREET, PO BOX 36 DMPKINSVILLE, KY 42167	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
	completed on April was assessed to he the left hand and to assistance of staff fingiene, and bathin A review of the quarestorative screen or revealed resident ### passively make a fishand; however, the keep the left hand on the left and right functional limitation WFL was defined as available range of make as interven active assist range of bilateral upper and iminutes daily and to the charge nurse or evaluation. However facility had developed	12, 2010, revealed resident #5 Ive limited range of motion of require extensive to total or transfers, bed mobility, g. Iterly joint mobility and conducted on April 5, 2010, 5 was assessed to be able to st and fully open the right resident was identified to linched. The screening also ght hands were within (WFL). The screen noted is having 75 to 100 percent of	F	318	quarterly. Individualized interventions will be put on care plan. DON, ADON and therapy will meet monthly discuss any issues. 4) DON will perform audit of least five residents per more ensure resident has been assessed accurately and carplanned for their specific problems. DON will report results to the QA committee quarterly.	on at oth to	11/12/2010
	Resident #5 was observed to be lying in bed on pillow underneath the handroll was observed to be seldent's bedside ta conducted on Septel revealed the facility seldent's	served on September 27, at 4:30 p.m., and at 5:40 p.m., and at 5:40 p.m., a wedged mattress with a e resident's knees. A ed to be lying on the able. A skin assessment mber 28, 2010, at 10:55 a.m., staff nurse was able to flex and with some stiffness					

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Event ID: TOHT11

Facility ID; 100337

If continuation sheet Page 4 of 13

		AND HUMAN SERVICES MEDICAID SERVICES		,	FORM	APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	OVOL MALIE	TIPLE CONSTRUCTION		. 0938- 0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE S COMPLE	
	,	185168	B. WING		09/2	9/2010
NAME OF F	ROVIDER OR SUPPLIER		12	REET ADDRESS, CITY, STATE, ZIP CO	******	
MONRO	E HEALTH AND REHA	ABILITATION CENTER		706 N MAGNOLIA STREET, PO BO; TOMPKINSVILLE, KY 42167	₹ 367	.*
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COS (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 318	Continued From pa	ge 4	F 318		*	
	noted. The resident closed in a first and open the resident's "OH." The nurse w	It's left hand was noted to be when the nurse attempted to hand the resident called out as unable to flex the third, ere of the resident's left hand.	r 310			
	September 28, 201 exercises were produing bathing. CN interventions had no resident. CNA #3 frould "scream" who	cted with CNA #3 on 0, at 1:50 p.m., revealed ROM vided daily for resident #5 A #3 stated hand rolls or other of been provided for the urther stated the resident en staff attempted to rs of the resident's left hand.				
	Coordinator (RC) or 12:55 p.m., revealer conduct quarterly or the residents and to interventions to prevente RC stated resk when staff attempte	cted with the Restorative in September 28, 2010, at did the RC was responsible to contracture measurements of develop restorative event/maintain joint mobility, dent #5 would "jerk" back and to straighten the fingers of and and some stiffness had				
	been noted in the refurther stated the reconsisted of ambula active assist ROM cextremities. The Rorepresentatives also restorative plan of comade to have a their	esident's right hand. The RC sident's restorative program ation, communication, and			:	
	to Restorative Nursi resident was require	ity's policy/procedure related ing (no date) revealed each ad to be screened upon east every three months for			· · · · · · · · · · · · · · · · · · ·	

FORM CMS-2507(02-99) Previous Versions Obsolete

Event ID: TQHT11

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PRINTED: 10/13/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 MONROE HEALTH AND REHABILITATION CENTER TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X3) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 318 Continued From page 5 F 318 F 364 policy/procedure further noted that an individualized plan of care was required to be 1) Trays sampled by the survey developed to prevent deterioration, and to maintain/improve the resident's current level of team and the dietary manager function. during inspection were given a : F 364 463.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, F 364 new plate of warm food. The SS=F PALATABLE/PREFER TEMP pureed bread recipe was revised Each resident receives and the facility provides for the next meal. food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is 2) The week of 10/4/2010 palatable, attractive, and at the proper Dietary Manager, Administrator, temperature. and DON performed tray audits to determine the temperature This REQUIREMENT is not met as evidenced and taste of the food served. by: Any concerns were addressed Based on observation and interview, it was determined the facility falled to serve palatable immediately. At the resident foods at appropriate temperatures for residents council on 11/1/2010 the dietary on the A, B, and D Wings during the lunch and manager will speak to the dinner meals on September 27, 2010, and the breakfast meal on September 28, 2010. resident council about food temperatures and taste of food. The findings include: Any concerns will be addressed immediately. Observation of the lunch meal on the A Wing, on September 27, 2010, revealed the first meal tray was served at 1:32 p.m. (Eastern Daylight Time). 3) On 10/8/2010 Dietician A facility staff person removed the last tray from educated all staff members on the cert at 2:02 p.m., 30 minutes later. Two the importance of serving tasty surveyors intercepted the food tray to conduct a meals. Temperature recording palatability test with the participation of the Dietary Manager (DM). The temperature of the pureed logs and Tray Delivery Policy meal was as follows: fish - 98 degrees were revised by the dietician. On Fahrenheit, mashed potatoes - 108 degrees 10/22/2010 Dietician and dietary Fahrenheit, macaroni and cheese - 108 degrees

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manager will reeducate dietary

staff on the Serving Temperature

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Fahrenheit, Vitamin D milk - 50 degrees

Fahrenheit, and a vanilla shake supplement - 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING E. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 708 N MAGNOLIA STREET, PO BOX 367 MONROE HEALTH AND REHABILITATION CENTER TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TΛG TAG DEFICIENCY F 364 Continued From page 6 F 364 degrees Fahrenheit. A surveyor and the Dietary Policy and on the Tray Delivery Manager conducted palatability tests of the meal Policy. Dietary staff will be with both noting the fish, potatoes, and macaroni educated on the revised and cheese were warm and bland to taste. The temperature recording logs and Dietary Manager stated the milk and shake were warm and not as cold as they should have been. procedures. Dietary Manager ordered new wells and lids for Observations were conducted on September 27, the steam table, dietary staff 2010, during the dinner meal tray pass on the D members are ensuring that the Wing. Observation revealed the first meal tray was passed at 6:32 p.m., and the last meal tray plate warmer is kept at its was passed at 7:02 p.m., 30 minutes later. The warmest temperature, cold last meal tray was intercepted by two surveyors products are put in the freezer along with the presence of the Dietary Manager. prior to meals being served, and Temperatures were taken of the fortified liquid diet meal. Temperatures were noted as follows: steam table element was fixed by sweet potatoes - 112 degrees Fahrenheit, ham maintenance staff. The order of 120 degrees Fahrenheit, bread with milk - 80 tray pass has been changed so degrees Fahrenheit, milkshake - 56 degrees Fahrenheit, and Vitamin D milk - 48 degrees that trays are served in a timely Fahrenheit. After a palatability test was manner. completed, the Dietary Manager stated the food was barely warm, was bland, and he/she would 4) Dietary Manager, have sent the food back to the kitchen at these Administrator, and DON will temperatures. perform test tray audits weekly. Further observations were conducted on Results will be reviewed by the September 28, 2010, at 8:43 a.m., on the B Wing NAR committee weekly. Dietary during the breakfast meal. Observation revealed Manager will report results to the last meal tray was intercepted at 9:12 a.m., due to the extended timeframe of meal delivery to the quarterly QA committee. the residents. The meal tray was intercepted by two surveyors and the DM. Temperatures of the 11/12/2010 puree diet were as follows: oatmeal - 118 degrees Fahrenheit, bacon - 102 degrees Fahrenheit, eggs - 90 degrees Fahrenheit, gravy -88 degrees Fahrenhelt, and Vitamin D milk - 48 degrees Fahrenhelt. The Dietary Manager stated the food temperatures were not acceptable.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MONROE HEALTH AND REHABILITATION CENTER 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 364 | Continued From page 7 F 364 During the Resident Group Interview conducted on September 28, 2010, at 4:00 p.m. - 4:30 p.m. (EDT), residents #14, #21, #22, and #23 revealed the food was cold when served to these residents. The residents stated they had reported these concerns to facility staff but nothing had been done to correct the identified problem with cold food temperatures. An interview with the Dietary Manager (DM) and Administrator conducted on September 28, 2010, at 10:40 a.m., revealed they did not check temperatures or conduct palatability tests at the point of service to ensure the food temperatures and taste of the foods were acceptable. They further revealed the facility did not have a policy regarding food temperatures at point of service or F371 regarding a required timeframe to deliver trays to residents. 1) On 9/28/2010 Dietary Interview with the Dietitian on September 28, Manager disposed of all 2010, at 9:28 a.m., revealed meal tray pass outdated or unlabeled food and should be completed in 10-15 minutes. drinks. Dietary Manager called F 371 483.35(i) FOOD PROCURE, F 371 vendor and requested new ice SS=E STORE/PREPARE/SERVE - SANITARY cream freezer. On 9/29/2010 The facility must -Vendor supplied kitchen with (1) Procure food from sources approved or new ice cream machine. considered satisfactory by Federal, State or local authorities; and 2) On 9/28/2010 Dietary (2) Store, prepare, distribute and serve food under sanitary conditions manager checked entire refrigerator and freezer for outdated and unlabeled products. No additional items were found. This REQUIREMENT is not met as evidenced PORM CMS-2567(02-98) Provious Versions Obsolets

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Received Time Oct. 22. 2010 10:50AM No. 3674

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 10/13/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING A, WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 MONROE HEALTH AND REHABILITATION CENTER TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D PREFIX PROVIDER'S PLAN OF CORRECTION (XS) -COMPLETION DATE PREFIX TAG EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 371 Continued From page 8 F 371 3) Dietician and dietary manager have reviewed the Refrigerated Based on observation and interview, the facility failed to store, prepare, and distribute foods under and Frozen Food Storage Policy. sanitary conditions. On 10/22/10 Dietician and dietary manager will educate The findings include: dietary staff on this policy Observations were conducted with the Dietary focusing on proper labeling and Manager of the kitchen refrigerator on September rotating foods for use. Dietary 28, 2010, at 10:25 a.m. (EDT). The following items were observed to be outdated and stored in. Manager updated cleaning the kitchen refrigerator. schedule to include daily checks of the Refrigerator and Freezer. One container of diet pears, dated September 18, Any outdated or unlabeled foods One container of Parmesan cheese, dated May will be disposed of immediately. 11, 2010. On 10/22/2010 Dietary Manager One jar sweet relish, opened and partially used, will reeducate staff members of not dated. the importance of properly One-half container of shredded cheese, dated September 15, 2010. defrosting the ice cream freezer One pitcher of diet orange drink, dated and that all problems with September 21, 2010. equipment need to be reported One pitcher of diet lemonade, dated September to her immediately. 16, 2010, One container thickened dairy milk, dated September 17, 2010. 4) Dietary Manager or her One container sweetened tea, dated September designee will monitor storage 24, 2010. areas weekly to ensure proper One container thickened punch, dated September 24, 2010. food storage. Audits will be reviewed weekly by the Observation of the kitchen conducted on administrator. Results will be September 28, 2010, at 10:45 a.m., revealed an reported to the QA committée ice cream freezer with the lid broken, seal not intact, and foam inside of the lid visible. The ice on a quarterly basis.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TOXT:1

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11/12/2010

cream freezer was observed to have

approximately one-half inch of condensation and ice buildup. The ice cream freezer was noted to

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/13/2010 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION	(X3) DATE BURVEY COMPLETED	
		185168	B, WING	HIP (INPLICATION OF THE PROPERTY OF THE PROPER	09/2	29/2010
•	PROVIDER OR SUPPLIER E HEALTH AND REH	ABILITATION CENTER	70	ET ADDRESS, CITY, STATE. ZIF CODE S N MAGNOLIA STREET, PO BOX: SMPKINSVILLE, KY 42167		
(XA) ID PREFIX TAG	(EACH DEFICIENC	ATEMEN'I OF DEFICIENCIES Y MUST BE PRECEDED BY FLILL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
F 371	Continued From pa have several dents	age 9 and rust on the outer surface.	F 371	F465		
	September 28, 20 and at 10:45 a.m., refrigerator were reopened and discar stated the dietary sithe refrigerators de as indicated. The only be kept for the the date of opening that condensation could cause a free which could affect product. Note: All times don Time. 483.70(h) SAFE/FUNCTION/E ENVIRON The facility must pr	Dietary Manager (DM) on 10, at 10;12 a.m., 10:25 a.m., revealed items in the equired to be dated when ded after three days. The DM staff was responsible to check ally and remove outdated items DM stated that items should ee days in the refrigerator from to or preparing. The DM stated buildup in the ice cream freezer zing and thawing process, the taste and quality of the currented per Eastern Daylight AL/SANITARY/COMFORTABL ovide a safe, functional, ortable, environment for the bublic.	F 465	1) The week of 10/24/2019 Housekeeping will clean of and baseboards in B2, B4 B7, B8, B9, B13, B15, B16, C4, C6, C7, C8, C9, C10, C1 D6, D7, D8, and D9. Housekeeping will clean be toilets in B14, D2, and D8 Housekeeping will clean geshower room. Housekeeping will clean geshower room. Housekeeping and Mainted Staff members will clean soon hallways. The week of 10/31/2010 Housekeeping wax and buff med room fland will clean counters and cabinets.	corners , B5, B6, , C1, C2, , L2, D4, pehind crout in ping ce enance elir vents g will oors	
	by: Based on observatifailed to provide efficient annue service sanitary, functional, for residents, staff, tiles were observed of soil was observed and the chests of di	NT is not met as evidenced ion and interview, the facility ective housekeeping and ses necessary to maintain a and comfortable environment and the public. Missing floor in resident rooms, a buildup d in corners of resident rooms, rawers in five (5) resident ed to be scraped/scarred.		Prior to 11/11/2010 Maintenance Staff will sar doors on A1, A2, A7, A10, A12, A13, A15, B3, B4, B9, B14, B15, C8, C10, C12, D5 D7, and D11 ensuring that are not splintered and haz to our residents. Beginnin 11/1/2010 door guards an	A11, 810, i, D6, doors ardous g on	

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Event ID:TOHT11

Facility ID: 100337

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PRINTED: 10/13/2010

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES					D: 10/13/2010	
		& MEDICAID SERVICES					APPROVED	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3)	ALII TU	PLE CONSTRUCTION		0. 0938-0391	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING				(X3) DATE SURVEY COMPLETED	
		185168	B. W	NG _		nar	29/2010	
NAME OF F	ROVIDER OR SUPPLIER			STD	EET ADDRESS, CITY, STATE, ZIP CODE		23/2010	
MONRO	E HEALTH AND REHA	ABILITATION CENTER	,	70	DE N MAGNOLIA STREET, PO BOX 3 OMPKINSVILLE, KY 42167			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFIDIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 465			F	465	doors can be fixed in a mo	Nr.		
		n A Hall and C Hall were			attractive manor.			
	crout in the chaves	reas of chipped paint and the areas was discolored.			ottractive manor.			
	Splintered/scarred	doors and door frames were			The week of 10/17/2010			
	Diserved in twenty-	one (21) resident rooms, I to be missing under			Maintenance Staff sanded	l and		
		nd air conditioners. A scraped			refinished chest of drawer	rs in		
		e observed in the wall in two	•	. '	resident rooms B1, B3, C13, D5,			
(2) resident rooms. The ice machine on the D.				and D7. Maintenance Staf				
	Hall was observed to have mildew/mold on the inside. Return air vents on C Hall and B Hall			1	filled in holes and Scrapes			
				1	rooms C12 and D9.	,,,		
	Roth medication roo	ave a heavy buildup of dust. oms were observed to have	•	ĺ	roomp cire and by,			
		countertops, debris inside			The week of 10/24/2010			
ļ	drawers, and a built	dup of dirt on the floors. The			Maintenance staff will put	down		
	medication carts we	ere also observed to have		ļ	tile under the HVAC units			
i		dried spills on the tops/sides			C10, D3, D7, D8, and D9.	III Cay	İ	
į		ers. A tube feeding pump in room was observed to be		j	C10, D3, D7, D6, and D3.			
ļ		an substance on it. The tube		- !	Before 11/11/2010 Mainte	Anance		
		n A-2 was observed to be		. !	Director will have an artist			
;		dried tan substance on it.			up murals in shower room.			
				į	nh marais in sitower 100th			
	The findings include	:		Ì	The week of 10/17/2010 N	Jursing		
	Observations of the	facility from September	•		. staff cleaned medication of	_	.	
		ed the following areas were in		!	both medication rooms. A			
	need of maintenance	e/housekeeping services:		Ì	has cleaned tube feeding p	-		
'				ı	·• ·	•		
		of soil was observed at the		İ	room A1 and poles in the I	nea		
. 1		rames and/or baseboards in B-4, B-5, B-6, B-7, B-8, B-9,		ļ	room.			
	B-13, B-15, B-16, C	-1, C-2, C-4, C-6, C-7, C-8,			2) By 10/29/2010 Houseke	aning		
ļ		4, D-6, D-7, D-8, and D-9.		}	and Maintenance Supervis	·		
1	0.0-11-1-1-1				•			
		edges and/or chipped			tour the entire facility to o	•		
		served in resident rooms A-1, , A-12, A-13, A-15, B-3, B-4,	,		for safe/functional/sanitar	•	i	
}		6, C-8, C-10, C-12, D-5, D-6,			comfortable environment.	Area		
	•			- 1			•	

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	10/13/2010	
		& MEDICAID SERVICES			FORM	APPROVED 0.0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILL	LTIFLE CONSTRUCTION DING	(X3) DATE S	SURVEY	
		185168	B. WING		00/	09/29/2010	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		C9/Z010	
MONRO	E HEALTH AND REHA	ABILITATION CENTER		706 N MAGNOLIA STREET, PO BO TOMPKINSVILLE, KY 42167	X 367		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD RE	(X6) COMPLETION DATE	
F 465	Continued From pa	ge 11	F 46	75			
	D-7, and D-11.		. , , , , , ,	be addressed. A plan of	faction	,	
] 			will be developed for co			
•	3. Chests of drawe	rs in resident rooms B-1, B-3,		not needing immediate			
	C-13, D-5, and D-7 were observed to be scraped and scarred.			attention,			
	4. Holes/scrapes w	ere observed in resident		3) Housekeeping staff n	nembers		
	rooms C-12 and D-9,			will begin cleaning med	room at		
ļ	5. Tiles were missir	on under the air condification		3:00pm each day. Hous	sekeeping		
	5. Tiles were missing under the air conditioners in resident rooms C-5, C-10, D-3, D-7, D-6, and D-9.			Manager will add med i	room to		
•				buffing and waxing sche	edule.		
	6. The floor behind the toilets in resident rooms		•	Housekeeping Manager	added		
	B-14. D-2. and D-8 v	were observed to be		cleaning the outside of	the ice		
•	discolored.			machine to the daily cle	aning		
	3 3 3 4 4 4 4			schedule, has added bar	seboards,	,	
1	/. The Central Bath	s on A Hall and C Hall were eas of chipped paint and		corners, and behind toil	ets to the		
·	solled grout in the st	nower area.		weekly cleaning schedu	le, has		
		•	•	added cleaning the insid			
!	8. The ice machine	on D Hall was observed to		ice machine to the quar	terly		
	dispenser,	n the inside of the ice		cleaning schedule and ti	,		
	alopelise,	·	•	vents to the monthly cle			
1	The return air ver	nts on D Hall and on B Hall		schedule. On 11/5/2010	-		
	were observed to co	ntain a heavy buildup of dust,	_	Housekeeping Manager	will		
	10 The medication	rooms on the A/B and C/D		educate the housekeepe	ers on the		
	units were observed	to have soiled		new cleaning schedule.		. [
	counters/cabinets an	d drawers. Debris was		•			
		drawers. The floors were		On 11/5/2010 DON will			
	observed to have a t	leavy bulldup of oirt.		reeducate staff member		. 1	
	11. Medication carts	in both medication rooms		nursing cleaning schedu			
	were observed to be	solled with dried substances.		proper cleaning technique			
	and with powder and	debris in the drawers.		Dirty tube feeding poles			
• .	12. A tube feeding p	ole in resident room A-1 was		placed in the soiled utilit	y room.		

FORM CMS-2567(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SCLIA IDENTIFICATION NUMBER:	(XX) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185158	B, WING		09/2	9/2010	
NAME OF PROVIDER OR SUPPLIER MONROE HEALTH AND REHABILITATION CENTER		abilitation center		REET ADDRESS, CITY, STATE, ZIP CO 706 N MAGNOLIA STREET, PO BOX TOMPKINSVILLE, KY 42167	OE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TRMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(%5) COMPLETION DATE	
F 465	substance. A tube medication room w solled with a dried the interview with the Housekeeping Supthe environmental the September 29, 201 that they attempted	heavy buildup of a dried tan feeding pump in the A/B as observed to be heavily	F 466	Clean poles will be place med room. Maintenance staff men begin refinishing or pur one chest of drawers per over the next year Maintenance staff will apply kick plate door guards to all doors facility. Holes and Scrap rooms will be fixed week reported to maintenance room round committee Maintenance staff men ensure touch up paint it rooms at least quartering.	nbers will chasing er week. ntenance es and in the nes in ckly after ce by the nshower		
				4) The housekeeping me her designee will check resident rooms, the ice the air vents, the shower and the med room week cleanliness. DON will clear for cleanliness more Maintenance Director versions a Job Task Sheet to the Administrator weekly. Administrator will ensuit the maintenance staff a following Job task scheem monitoring will be reposited.	five machine, er rooms kly for neck med othly. The vill turn in The re that re		

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STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION	(X1) PROVIDER/SUPPLI	er/CLIA JMBER:	(X2) MULTIPLE CONSTRUCTION A. RUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	100037			09/2	9/2010	
MONROE HEALTH AND REHA	ABILITATION CEN	706 N M		REET, PO BOX 367		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRÉCEDED BY SCIDENTIFYING INFORM	FINI	ID PREFIX TAG	PROVIDER'S PILAN OF COI (FACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
				the QA committee on a q basis.	uarterly	
		:		15.	1:	/12/2010
				.		
		-			. • •	· .
						,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Addendum

PRINTED: 10/13/2010. FORM APPROVED OMB NO, 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				ÓN	1B NO, 0	938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE CON	STRUCTION	(X3)	DATE SUR COMPLETE	
		185168	B. Wil	4G		· '	09/29/	2010
NAME OF F	PROVIDER OR SUPPLIER		1		IRESS, CITY, STATE		December 1	
MONRO	E HEALTH AND REHA	BILITATION CENTER			gnolia street, NSVILLE, KY 42			
(X4) ID PREFIX · TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL 3C IDENTIFYING INFORMATION)	ID PREF TAG		EACH CORRECTIVE OSS-REFERENCED			(XS) DOMPLETION DATE
F 318	'.'	=	F	318				
	was assessed to ha the left hand and to	12, 2010, revealed resident #5 ve limited range of motion of require extensive to total or transfers, bed mobility, g.		inte	rterly. Individual rventions will be plan. DON, AD	e put on the OON and		
,	restorative screen or revealed resident #5 passively make a fishand; however, the keep the left hand clinoted the left and right functional limitation WFL was defined as available range of m			disc 4) F (No DOI leas ensi	rapy will meet nows any issues. For the next three vember, Decement will perform a set five residents has essed accurately and for their spansor.	e months ber, January) udit on at per month to been and care	-	
	#5 revealed the facility be at risk for continued weakness. Interventional active assist range of bilateral upper and to minutes daily and to the charge nurse or revaluation. However facility had developed	rative care plan for resident ity had identified the resident racture development due to dons included to provide f motion (ROM) exercises to over extremitles at least 15 report any decline in ROM to restorative nurse for further there was no evidence the d individualized interventions ant's Impaired ROM of the		resu	blems. DON wil ults to the QA co rteriy.	•		11/12/2010
1	2010, at 3:30 p.m., a to be lying in bed on oillow underneath the nandroll was observed the testident's bedside tall conducted on Septente vealed the facility s	erved on September 27, at 4:30 p.m., and at 5:40 p.m., a wedged mattress with a president's knees. And to be lying on the pole. A skin assessment on the cole. A skin assessment of the co	· ·					

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Event ID: TOHT11

Facility ID: 100337

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UEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION ... A. BUILDING (XS) DATE SURVEY . COMPLETED

		185168	s. WING_		09/29/2010
	ROVIDER OF SUPPLIER E HEALTH AND REHA	BILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT OROSS-REFERENCED TO THE APPR DEFICIENCY)	DID BE COMPLETION
F 364	Manager conducted with both noting the and cheese were were well and cheese were were warm and not as conducted warm and not as conducted warm and not as conducted was passed at 6:32 was passed at 7:02 last meal tray was along with the present meal. Temperatures were diet meal. Temperatures were degrees Fahrenheit, and Vita Fahrenheit, and Vita Fahrenheit. After a completed, the Diet was barely warm, wheve sent the food it temperatures. Further observation September 28, 2011 during the breakfast the last meal tray well.	ge 6 A surveyor and the Dietary of palatability tests of the meal fish, potatoes, and macaroni arm and bland to taste. The ated the milk and shake were ald as they should have been. conducted on September 27, ther meal tray pass on the Dietary pass on the Dietary part and the last meal tray p.m., 30 minutes later. The intercepted by two surveyors ence of the Dietary Manager taken of the fortified liquid atures were noted as follows; 2 degrees Fahrenheit, hamilitus head with milk - 80, milkshake - 56 degrees palatability test was ary Manager stated the food as bland, and he/she would back to the kitchen at these swere conducted on 0, at 8:43 a.m., on the 8 Wing the meal. Observation revealed as intercepted at 9:12 a.m., timeframe of meal delivery to	F 364	10/22/2010 Dietician and dietary manager will reeducate dietary staff on the Serving Temperature Policy and on the Tray Delivery Policy. Dietary staff will be educated on the revised temperature recording logs and procedures. Dietary Manager ordered new wells and lids for the steam table, dietary staff members are ensuring that the plate warmer is kept at its warmest temperature, cold products are put in the freezer prior to meals being served, and steam table element was fixed by maintenance staff. The order of tray pass has been changed so that trays are served in a timely manner. 4) For the next three months (November, December, January) Dietary Manager, Administrator,	
	two surveyors and to puree diet were as in degrees. Eahrenheit Fahrenheit, eggs - 9 88 degrees Fahrenheit	meal tray was intercepted by the DM. Temperatures of the follows: patmeal - 118, becon - 102 degrees O degrees Fahrenheit, gravy - 1eit, and Vitamin D milk - 48		and DON will perform test tray audits weekly. Results will be reviewed by the NAR committee weekly. Dietary Manager will	11/12/2010
	degrees Fahrenheit	. The Dietary Manager stated es were not acceptable.		report results to the quarterly QA committee.	·

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Facility ID: 100337

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE	& MEDICAID SERVICES		AND AND AND AND AND AND AND AND AND AND	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1/20 AUR TIELS CONSTRUCTION	OMB NO. 0938-03	
.		A BUILDING	COMPLETED	
	185168	E. WING	09/29/2010	
name of provider or supplier	. (STREET ADDRESS CITY STATE ZIP CODE	USIZSIZU' U	

MONRO	E HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO		
F 371	Continued From page 8	F 371				
	by:					
ŀ	Based on observation and interview, the facility	•	3) Dietician and dietary manager			
	failed to store, prepare, and distribute foods under sanitary conditions.		have reviewed the Refrigerated			
	serioury containers.		and Frozen Food Storage Policy.			
-	The findings include:		On 10/22/10 Dietician and			
			1			
	Observations were conducted with the Dietary	• '	dletary manager will educate			
1.	Manager of the kitchen refrigerator on September		dietary staff on this policy			
į	28, 2010, at 10:25 a.m. (EDT). The following items were observed to be outdated and stored in.		focusing on proper labeling and			
	the kitchen refrigerator:	, ,	rotating foods for use. Dietary			
}			Manager updated cleaning			
	One container of diet pears, dated September 18,		schedule to include dally checks			
	2010.		of the Refrigerator and Freezer.			
	One container of Parmesan chease, dated May		Any outdated or unlabeled foods			
	One jar sweet relish, opened and partially used,	ļ	will be disposed of immediately.			
. r	not dated.		On 10/22/2010 Dietary Manager	;		
	One-half container of shredded cheess, dated		will reeducate staff members of			
1 5	September 15, 2010,					
[]	One pitcher of diet orange drink, dated	· :	the Importance of properly			
	September 21, 2010.		defrosting the ice cream freezer			
. 1	One pitcher of diet lemonade, dated September 6, 2010.		and that all problems with			
	ne container thickened dairy milk, dated		equipment need to be reported	İ		
5	eptember 17, 2010.		to her immediately.	.		
	ne container sweetened tea, dated September			·		
24	4, 2010,	.	4) For the next three months			
2	ine container thickened punch, dated September 4, 2010.		(November, December, January)	•		
. -	1,2010.		Dietary Manager or her designee]'		
0	bservation of the kitchen conducted on		will monitor storage areas	İ		
56	eptember 28, 2010, at 10:45 a.m., revealed an		weekly to ensure proper food			
	e cream treazer with the lid broken seel not		storage. Audits will be reviewed	ļ		
ini	tact, and foam inside of the lid visible. The ice].	weekly by the administrator	1		
j an	eam freezer was observed to have	.				
ice	proximately one-half inch of condensation and a buildup. The ice cream freezer was noted to	Ĺ	Results will be reported to the	11/12/201		
, ,	The secondary treezed was troted to	. "	QA committee on a quarterly			

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Evant ID: TQHT11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A PUBLISHED A PUBLISHED

PRINTED: 10/13/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED		
185168		" AL WING.	and the second legislation of the second sec	09/	09/29/2010			
NAME OF PROVIDER OR SUPPLIER MONROE HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167					
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T PEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE		
F 465	observed to have a substance. A tube medication room w solled with a dried to An interview with the Housekeeping Supthe environmental to September 29, 201 that they attempted	Continued From page 12 observed to have a heavy buildup of a dried tan substance. A tube feeding pump in the A/B medication room was observed to be heavily solled with a dried tan substance. An interview with the Maintenance and Housekeeping Supervisors was conducted during the environmental tour at 10:00 a.m. on September 29, 2010. The Supervisors stated that they attempted to make facility rounds weekly to observe for maintenance and cleaning needs.		Clean poles will be placed in the med room. Maintenance staff members will begin refinishing or purchasing one chest of drawers per week. Over the next year Maintenance staff will apply kick plates and door guards to all doors in the facility. Holes and Scrapes in rooms will be fixed weekly after reported to maintenance by the room round committee. Maintenance staff members will ensure touch up paint in shower rooms at least quarterly.				
				4) For the next three moder, December, December, The housekeeping mans her designee will check resident rooms, the locathe air vents, the showed and the med room week cleanliness. DON will check to cart for cleanliness money maintenance Director was Job Task Sheet to the Administrator weekly. The maintenance of the	January) ager or five machine, r rooms dy for eck med thly. The ill turn in			

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Event ID: TQHT11

Faully id Alegying job task schedule influence sheet Page 13 of 13 monitoring will be reported to

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

aministrato 10/8

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegueres provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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Event ID: TQHT21

Facility ID: 100337

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 MONROE HEALTH AND REHABILITATION CENTER TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY K 025 Continued From page 1 K 025 During the Life Safety Code survey on September 29, 2010, at 11:15 a.m., with the Director of Maintenance, a fire/smoke barrier wall above the fire doors on the C Wing was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the Director of Maintenance on September 29, 2010, at 11:15 a.m., revealed the Director of Maintenance was unaware of the requirements pertaining to fire/smoke dampers or if there was a record of the dampers having been maintained. The Director of Maintenance stated there was also a fire/smoke damper on the D Wing. Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary, K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=D One hour fire rated construction (with 1/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 K029 NFPA 101 Life Safety Code and/or 19.3.5.4 protects hazardous areas. When Standard the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and 1) On 10/18/2010 Maintenance doors. Doors are self-closing and non-rated or Director Installed door closures field-applied protective plates that do not exceed on the corridor door to the 48 inches from the bottom of the door are laundry room and the medical permitted. 19.3.2.1 supply rooms

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10/22/2010 09:43

		E & MEDICAID SERVICES	T		FORM APPROVED OMB NO. 0938-0391		
Statement of Deficiencies and Plan of Correction		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		185168	. B. WING	01 - MANY BUILDING 01			
IAME OF I	PROVIDER OR SUPPLIER					9/2010	
	•	ABILITATION CENTER	706	et address, city, state, zip code n magnolia street, po box : MPKINSVILLE, KY 42167	E 367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 029	Continued From pa	age 2	K 029	2) On 10/18/2010 Mainter	nànce		
		•		Director observed other de	, '		
		,		throughout the building ar			
		·		determined door closures were			
	This STANDARD	is not met as evidenced by:		on all necessary doors.			
	falled to ensure the equipped with a se deficient practice a compartments, statwenty-six (26) resi capacity for 104 be day of the survey. The findings including the Life Safe 29, 2010, at 10:55 and Maintenance, a cor Medical Supply roo door closing device	ety Code tour on September a.m., with the Director of ridor door to the Laundry and ms were observed not to have s. Door closing devices are		3) On 10/18/2010 Mainter Director installed door closs On 11/5/2010 all staff mer educated on importance or closures. 4) Maintenance Director with the check doors to hazardous a monthly to ensure door closure on doors. QA results with the CA committed of the CA committed are on doors.			
	required on doors to rooms deemed to be a hazardous area. An interview on September 29, 2010, at 10:55 a.m., revealed the Director of Maintenance was unsure which rooms were considered hazardous areas that would require a door closing device. Reference: NFPA 101 (2000 Edition).				. · ·	11/12/20	
1	fire barrier having a or shall be provided extinguishing syster The automatic extin	s shall be safeguarded by a 1-hour fire resistance rating					

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sprinkler option is used, the areas shall be

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 MONROE HEALTH AND REHABILITATION CENTER TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (XS) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 029 Continued From page 3 K 029 separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boller and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2(3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous K056 NFPA 101 Life Safety Code K 056 NFPA 101 LIFE SAFETY CODE STANDARD Standard K 056 SS=D

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1) Maintenance Director

Eagle Fire Protection began

contacted Eagle Fire Protection.

installing sprinklers the week of

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If there is an automatic sprinkler system, it is

for the Installation of Sprinkler Systems, to

installed in accordance with NFPA 13, Standard

provide complete coverage for all portions of the building. The system is properly maintained in

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUI. TIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED 01 - MAIN BUILDING D1 B. WING 185168 09/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MONROE HEALTH AND REHABILITATION CENTER 705 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 056 Continued From page 4 K 056 accordance with NFPA 25, Standard for the 2) The facility has no other Inspection, Testing, and Maintenance of porches that exceeds four feet Water-Based Fire Protection Systems, It is fully supervised. There is a reliable, adequate water without sprinklers supply for the system. Required sprinkler systems are equipped with water flow and tamper 3) Maintenance Director switches, which are electrically connected to the contacted Eagle Fire Protection. building fire alarm system. 19.3,5 Eagle Fire Protection began installing sprinklers the week of 10/17/2010. This STANDARD is not met as evidenced by: 4) Maintenance Director will Based on observation and interview, the facility ensure that sprinkler heads are failed to ensure the outside canopies at the facility were of noncombustible or limited combustible inspected on a quarterly basis by construction or sprinkler protected as required. Eagle Fire Protection. This deficient practice affected one (1) of six (6) smoke compartments, staff, and six (6) residents. The facility has the capacity for 104 bads with a census of 104 on the day of the survey. 11/12/2010 The findings include: During the Life Safety Code survey on September 29, 2010, at 11:30 a.m., with the Director of Maintenance, two combustible canopies exceeding four feet in width located at the front entrance and smoking area of the facility were observed not to be sprinkler protected. Combustible canopies exceeding four feet in width must be sprinkler protected. An interview with the Director of Maintenance on September 29, 2010, at 11:30 a.m., revealed he/she was not aware of this requirement, Reference: NFPA 13 (1999 Edition). 5-13,8.1 FORM CMS-2587(02-99) Previous Versions Obsolete

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ATEMEN ID PLAN(T OF DEFICIENCIES OF CORRECTION	R MEDICARE & MEDICAID SERVICES ICIENCIES ICIENCIES ICIENCIES IDENTIFICATION NUMBER;			(X2) MUI TIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
			185168			**************************************	-	09/29/2010		
NAME OF PROVIDER OR SUPPLIER MONROE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167						
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency Must be preceded by Full Regulatory or LSC Identifying Information)		PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLIC CROSS-REFERENCED TO THE APPR DEFICIENCY)			II D RE	COMPLET DATE		
K 056	Sprinklers shall be or canoples excee Exception; Sprinkle	installed unding 4 ft (1.2 ars are pention of roof is of	! m) in width, litted to be omitted , nancombustible or	K 056						
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Facility ID: 100237